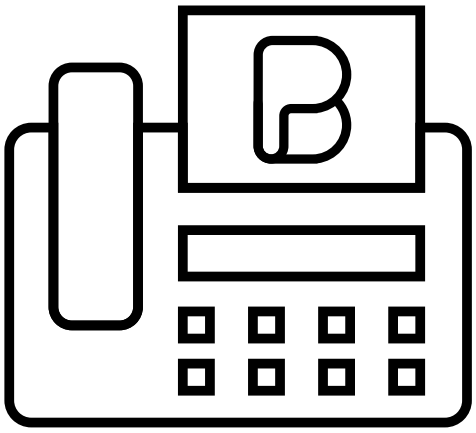
Bayview Pharmacy

Your modern compounding pharmacy.™

FAX COVER SHEET



Please fax your order to:

401-284-4506

3844 Post Road, Warwick RI 02886

Phone: 401 - 284 - 4505

www.bayviewrx.com

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Your modern compounding pharmacy. ™

This standardized order form helps ensure accurate, safe, and efficient prescribing of customized compounded medications. Please review the brief instructions below before completing or submitting any form.

For Prescribers

1. **Select the Formulation**
   Fill in the bubble next to the intended compounded product.
2. **Choose Directions/SIG**
   Select one of the provided SIG options or write custom instructions.
3. **Complete Patient Information**
   Include full name, DOB, address, phone number, and other information.
4. **Fill in Prescriber Information**
   Include your NPI, DEA (if required), phone, fax, and address.
5. **Sign and Date**
   Unsigned forms cannot be processed.
6. **Fax Completed Forms**
   Send to (401) 284-4506 or (401) 210-2757.

For Patients & Caregivers

- **Give this form directly to your healthcare provider**. They must complete and sign it before Bayview Pharmacy can prepare your medication.
- You may receive this form from a provider or facility; bring it to your next appointment if it has not yet been completed.
- Do **not** fill out the prescriber sections yourself. Your provider will enter your dosing instructions and clinical details.
- After we receive the prescription, we will reach out to the patient to go over the medication, allergies, shipping/pickup, and payment.

3844 Post Road, Warwick RI 02886
Phone: 401-284-4505
Fax: 401-284-4506
Alternate Fax: 401-210-2757
www.bayviewrx.com

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Prefer to skip the fax? Bayview Pharmacy accepts electronic prescriptions from all major EHR and e-prescribing platforms on the Surescripts network. Here's how to send your prescription electronically in three quick steps.

How to E-Prescribe

1. **Search for our pharmacy**
   In your EHR or e-prescribing platform, search the pharmacy directory for "Bayview Pharmacy" — or search by ZIP code 02886 and look for us in Warwick, RI.

2. **Verify you have the right location**
   Confirm the listing matches the details in the box below before selecting it.

3. **Enter the prescription and send**
   Enter the compounded medication exactly as it appears on the order form — product, strength, quantity, directions, and refills — then transmit. No fax needed; we take it from there.

Pharmacy Name	Bayview Pharmacy
Address	3844 Post Road, Warwick, RI 02886
NCPDP ID	4106882
NPI	1750455143
Phone	(401) 284-4505
Fax	(401) 284-4506

If your EHR requires a free-text compound entry, type the formulation name exactly as it appears in the Rx section of the order form.

Questions? Call (401) 284-4505 and one of our pharmacists will walk you through it.

NEW PRESCRIPTION ORDER FORM – PROGESTERONE

1 Patient Information

Last Name	First Name	MI
Address		Apt. #

City	State	ZIP	Phone Number
Date of Birth (mm/dd/yyyy)	Sex ○ M ○ F	Email	

2 Prescriber Information

Prescriber's Name	
Phone Number	Fax Number
Street Address	
City	State / ZIP
NPI	DEA

3 Medication Selection

PROGESTERONE – Slow-Release Oral Capsules (swallowed)	QUANTITY
☐ PRG-SR100 Progesterone 100 mg SR capsule	QTY: ☐ 30 ☐ 60 ☐ 90 ☐ 180 caps
☐ PRG-SR200 Progesterone 200 mg SR capsule	QTY: ☐ 30 ☐ 60 ☐ 90 ☐ 180 caps

PROGESTERONE – Troches & Rapid Dissolve (dissolved in the mouth)	QUANTITY
☐ PRG-TR100 Progesterone 100 mg troche	QTY: ☐ 30 ☐ 60 ☐ 90 units
☐ PRG-TR200 Progesterone 200 mg troche (wettable)	QTY: ☐ 30 ☐ 60 ☐ 90 units
☐ PRG-R50 Progesterone 50 mg rapid dissolve tablet	QTY: ☐ 30 ☐ 60 ☐ 90 units
☐ PRG-R100 Progesterone 100 mg rapid dissolve tablet	QTY: ☐ 30 ☐ 60 ☐ 90 units

PROGESTERONE – Topical (applied to the skin)	QUANTITY
☐ PRG-C Progesterone cream _____ mg/gm (10-100)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
☐ PRG-G Progesterone anhydrous gel _____ mg/gm (10-100)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm

CUSTOM – (other strength, base or form – call pharmacy to confirm)	QUANTITY
☐ _____	QTY: _____ units

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

- ☐ Take 1 dose by mouth at bedtime.
- ☐ Take 1 dose by mouth at bedtime on days _____ of each cycle.
- ☐ Apply _____ gm (or one metered pump) to the skin once daily, rotating sites.
- ☐ Other _____

X _____ _____

Prescriber's Signature Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10 Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – BI-EST

1 Patient Information

Last Name	First Name	MI
Address		Apt. #

City	State	ZIP	Phone Number
Date of Birth (mm/dd/yyyy)	Sex ○ M ○ F	Email	

2 Prescriber Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

3 Medication Selection

BI-EST – Topical Cream (estriol / estradiol)		QUANTITY
☐ BE5-C	Bi-Est 50/50 cream _____ mg/gm (0.25-2.5)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
☐ BE5-H	Bi-Est 50/50 cream _____ mg per 0.5 gm (0.25-1)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
☐ BE8-C	Bi-Est 80/20 cream _____ mg/gm (0.25-2.5)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
BI-EST – Anhydrous Gel		**QUANTITY**
☐ BE5-G	Bi-Est 50/50 gel _____ mg/gm (0.25-5)	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
☐ BE8-G	Bi-Est 80/20 gel 1 mg/gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
BI-EST – Troches		**QUANTITY**
☐ BE5-TR	Bi-Est 50/50 troche 1 mg	QTY: ☐ 30 ☐ 60 ☐ 90 units
☐ BE8-TR	Bi-Est 80/20 troche 1.25 mg	QTY: ☐ 30 ☐ 60 ☐ 90 units
CUSTOM – (other strength, base or form – call pharmacy to confirm)		**QUANTITY**
☐	_____	QTY: _____ gm

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

☐ Apply _____ gm (or one metered pump) to the skin once daily, rotating sites.

☐ Dissolve 1 troche in the mouth once daily.

☐ Other _____

X _____ _____

Prescriber's Signature Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10

Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – BI-EST + PROGESTERONE

1 Patient Information

Last Name	First Name	MI
Address		Apt. #
City	State	ZIP	Phone Number
Date of Birth (mm/dd/yyyy)	Sex ○ M ○ F	Email

2 Prescriber Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

3 Medication Selection

BI-EST + PROGESTERONE – Topical Cream — **QUANTITY**

- ☐ **BEP5-C** 50/50 cream: Bi-Est _____ mg + progesterone _____ mg per gm — **QTY:** ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
- ☐ **BEP8-C** 80/20 cream: Bi-Est _____ mg + progesterone _____ mg per gm — **QTY:** ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
- ☐ **BEP8-SYR** 80/20: Bi-Est 0.1 mg + progesterone 10 mg per 0.1 mL — **QTY:** _____ syringes

BI-EST + PROGESTERONE – Anhydrous Gel — **QUANTITY**

- ☐ **BEP5-G** 50/50 gel: Bi-Est 2 mg + progesterone 100 mg per gm — **QTY:** ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
- ☐ **BEP8-G** 80/20 gel: Bi-Est 2.5 mg + progesterone 100 mg per gm — **QTY:** ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm

BI-EST + PROGESTERONE – Troches — **QUANTITY**

- ☐ **BEP5-TR** 50/50 troche: Bi-Est 1 mg + progesterone 50 mg — **QTY:** ☐ 30 ☐ 60 ☐ 90 units
- ☐ **BEP8-TR** 80/20 troche: Bi-Est 1.25 mg + progesterone 100 mg — **QTY:** ☐ 30 ☐ 60 ☐ 90 units

CUSTOM – (other strength, base or form – call pharmacy to confirm) — **QUANTITY**

- ☐ _____ **QTY:** _____ gm

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

- ☐ Apply _____ gm (or one metered pump) to the skin once daily, rotating sites.
- ☐ Dissolve 1 troche in the mouth once daily.
- ☐ Other _____

X _____ _____

Prescriber's Signature — Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name — Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10

NEW PRESCRIPTION ORDER FORM – ESTRADIOL TOPICAL

1 Patient Information

Last Name	First Name	MI
Address		Apt. #

City	State	ZIP	Phone Number
Date of Birth (mm/dd/yyyy)	Sex ○ M ○ F	Email	

2 Prescriber Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

3 Medication Selection

ESTRADIOL – Topical Cream (VersaBase, rubbed into the skin once daily)	QUANTITY
☐ E2C-05 Estradiol cream 0.5 mg/gm	QTY: ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm
☐ E2C-1 Estradiol cream 1 mg/gm	QTY: ☐ 30 ☐ 60 ☐ 90 gm
☐ E2C-15 Estradiol cream 1.5 mg/gm	QTY: ☐ 90 ☐ 180 gm
☐ E2C-2 Estradiol cream 2 mg/gm	QTY: ☐ 30 ☐ 90 gm
☐ E2C-4 Estradiol cream 4 mg/gm	QTY: ☐ 90 gm
ESTRADIOL – Prefilled Syringes	**QUANTITY**
☐ E2C-SYR Estradiol 1 mg / 0.1 mL prefilled syringes	QTY: ☐ 9 syringes (27 gm)
CUSTOM – (other strength, base or form – call pharmacy to confirm)	**QUANTITY**
☐ _____	QTY: _____ gm

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

☐ Apply _____ gm (or one measured syringe) to the skin once daily, rotating sites, or as directed.

☐ Other _____

X _____ _____

Prescriber's Signature Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10 Pharmacy Fax Number

NEW PRESCRIPTION ORDER FORM – DHEA

1 Patient Information

Last Name	First Name	MI
Address		Apt. #

City	State	ZIP	Phone Number
Date of Birth (mm/dd/yyyy)	Sex ○ M ○ F	Email	

2 Prescriber Information

Prescriber's Name		
Phone Number	Fax Number	
Street Address		
City	State	ZIP
NPI	DEA	

3 Medication Selection

DHEA – Oral Capsules — **QUANTITY**

☐ **DHE-CAP** DHEA capsule _____ mg (5-50) — **QTY:** ☐ 30 ☐ 60 ☐ 90 caps

DHEA – Vaginal Ovules — **QUANTITY**

☐ **DHE-OV** DHEA vaginal ovule _____ mg (3.25-6.5) — **QTY:** _____ ovules

DHEA – Topical (strength to prescriber order) — **QUANTITY**

☐ **DHE-C** DHEA topical cream _____ mg/gm — **QTY:** ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm

☐ **DHE-G** DHEA topical gel _____ mg/gm — **QTY:** ☐ 30 ☐ 45 ☐ 60 ☐ 90 gm

CUSTOM – (other strength, base or form – call pharmacy to confirm) — **QUANTITY**

☐ _____ **QTY:** _____ units

REFILLS (circle one)

1 2 3 4 5 6 7 8 9 10 PRN NR

DIRECTIONS/SIG + SIGNATURE

☐ Take 1 dose by mouth at bedtime.

☐ Insert 1 ovule vaginally at bedtime, or as directed.

☐ Apply _____ gm (or one metered pump) to the skin once daily, rotating sites.

☐ Other _____

X _____ _____

Prescriber's Signature — Date

4 Fill out the Pharmacy Name and Fax number, then fax it to the Pharmacy.

_____ _____

Pharmacy Name — Pharmacy Fax Number

The pharmacy name & fax # cannot be pre-printed in order to comply with RI Law 216-RICR-40-15-1 section 1.3A10